426 - CRS REFERRALS, ENROLLMENT, AND COVERAGE GUIDELINES

EFFECTIVE DATE: 01/01/11, 10/01/13, 08/01/14

REVISION DATE: 10/25/12, 02/07/13, 07/17/14

STAFF RESPONSIBLE FOR POLICY: DHCM AND DMS

I. PURPOSE

This Policy applies to Acute Care, ADHS/BHS, CRS, DES/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy defines the processes used to accept and process applications and referrals to the CRS program, CRS redeterminations, and delineates the responsibility for coverage and payment of CRS conditions as well as other services that are the responsibility of the respective Contractor.

II. DEFINITIONS

ACTIVE TREATMENT Active Treatment means there is a current need for treatment or evaluation for continuing treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition (A.A.C. R9-22-1301).

CRS APPLICATION A submitted form with additional documentation required by the AHCCCS DMS in order to make a determination whether an AHCCCS member is medically eligible for CRS.

CRS CONDITION Any of the covered medical conditions in A.A.C. R9-22-1303.

REDETERMINATION A decision made by the AHCCCS DMS regarding whether a member continues to meet the requirements in A.A.C. R9-22-1302.

III. POLICY

The CRS Contractor provides covered services to individuals who have been confirmed as having a CRS covered condition requiring active treatment, as defined in A.A.C. R9-22-1303 and AMPM Policy 330, who have been approved for the CRS program by the Division of Member Services (DMS). AHCCCS may request, at any time, that the CRS Contractor submit medical documentation for the determination of continued eligibility. DMS is responsible for processing and responding to requests for CRS enrollment and will accept and process a referral and application in accordance with this Policy.

AHCCCS members under the age of 21 shall be enrolled into the CRS Program when the presence of a CRS-covered condition requiring active treatment, as defined by AMPM Policy 330, is confirmed through medical review by DMS. Applicants who are not enrolled in Title XIX/XXI cannot be enrolled in the CRS Program. Members are permitted to opt out of, or refuse enrollment into, the CRS program.

Regardless of the CRS Coverage Type, the CRS Contractor is responsible for care and services effective from the date of the member's enrollment into the CRS Program through the date of disenrollment and also during Prior Period Coverage (PPC) as noted in section D of this Policy. The CRS Contractor shall pay for **all** medically necessary services related to the member's CRS condition as well as other covered services based on the member's CRS Coverage Type. The CRS coverage types are described below.

CRS COVERAGE TYPES:

1. CRS Fully Integrated

   This coverage type is applicable to members receiving all services from the CRS Contractor including acute care, behavioral health, and CRS-related services.

2. CRS Partially-Integrated – Acute

   This coverage type is applicable to American Indian (AI) members receiving all acute care and CRS-related services from the CRS Contractor and receiving behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA).

3. CRS Partially-Integrated – Behavioral Health (BH)

   This coverage type is applicable to CMDP or DDD members receiving all behavioral health and CRS-related services from the CRS Contractor and receiving acute care services from the primary program of enrollment.

4. CRS Only

This coverage type is applicable to members receiving all CRS related services from the CRS Contractor, receiving acute care services from the primary program of enrollment, and receiving behavioral health services as follows:

a. CMDP and DDD AI members from a TRBHA
b. American Indian Health Program (AIHP) members from a T/RBHA
c. CRS only also includes ALTCS/EPD AI Fee-For-Service members.

IV. PROCEDURE

A. REFERRAL/APPLICATION

1. Form Requirements

A CRS referral/application shall be submitted to DMS for a medical eligibility determination. A copy of the required CRS referral/application and instructions are available on the AHCCCS website at the following link: CRS Referral.

a. The completed Application for Enrollment into AHCCCS CRS form may be faxed, mailed, or delivered in person to DMS as indicated on the AHCCCS website.
b. Prior to submitting the completed CRS referral/application form, the Contractor shall discuss the referral and possible health plan change with the parent/authorized representative.
c. The following additional documentation is required with submission of the application:
    i. Documentation supporting the medical diagnosis and the need for treatment; and
    ii. Diagnostic testing results that support the medical diagnosis.

2. Processing

a. DMS will verify Title XIX/XXI enrollment.
b. If further information is needed in order to make a determination of medical eligibility, DMS will contact the appropriate parties to request the information.

3. Enrollment

a. DMS will enroll the applicant into the CRS Program, by coverage type, effective on the same date as the eligibility determination, including those applicants who may be hospitalized at the time of the CRS determination.

4. Notifications

   a. When a determination is made, notification will be provided to the following parties:
      i. Applicant/authorized representative;
      ii. Referral source, if authorized; and
      iii. The current AHCCCS Contractor, if applicable.
   b. If approved for CRS enrollment, the CRS Contractor will also be notified.

DMS will provide information related to the CRS qualifying condition(s) that are identified during the eligibility determination process. DMS may also provide information received by DMS for purposes of eligibility determination for the CRS Program regarding care, services or procedures that may have been approved or authorized by the member's current health plan. It will be the responsibility of the CRS Contractor to ensure that the information provided by DMS is made available to the appropriate areas and staff within its organization who may need the information. It remains the responsibility of the CRS Contractor and the Acute Care Contractor to also appropriately transition the member utilizing established transition processes.

B. MEMBERS TURNING 21

Shortly before a member who is enrolled in the CRS Program turns 21 years of age, s/he is provided a one-time opportunity to remain enrolled with the CRS Contractor.

The month prior to the month the member will turn 21, the member will be notified of his/her opportunity to either continue enrollment with the CRS Contractor or enroll with another AHCCCS Contractor and will be informed of the process for doing so.

If a member does not timely notify the AHCCCS CRS Enrollment Unit to continue enrollment in the CRS Program, s/he will be disenrolled from the CRS Contractor at the end of his/her birth month and will be auto-enrolled with another AHCCCS Contractor.

The member will then be given a 30 day choice of Acute Care Contractor period.

If a member turning 21 years of age fails to timely notify the AHCCCS CRS Enrollment Unit to continue enrollment in the CRS Program, the member will not be permitted to reenroll with the CRS Program at a later date.

C. CONTRACTOR RESPONSIBILITIES FOR CRS SERVICES

AHCCCS members may elect to use his/her private insurance network (providers) or Medicare providers to obtain health care services, including those for treatment of the

CRS condition. Contractor responsibilities for payment of services for treatment of the CRS condition, when a member uses private insurance or Medicare, are further outlined below.

1. CRS Contractor Responsibilities
   a. Members under 21 years of age who are determined to have a qualifying CRS condition will be enrolled with the CRS Contractor. The CRS Contractor is responsible for payment for services provided to its enrolled members as outlined in the four CRS coverage types above and as set forth in AHCCCS rules and policy.
   b. If a member enrolled with the CRS Contractor uses private insurance or Medicare for a CRS covered condition, then the CRS Contractor is the secondary payer responsible for all applicable deductibles and copayments and for application of the appropriate coordination of benefits activities for members as outlined in ACOM Policy 434.
   c. When the member's private insurance or Medicare expires, does not cover the CRS condition,is exhausted for the CRS-covered conditions, or certain annual or lifetime limits are reached for the CRS-covered condition, the CRS Contractor is responsible for all covered CRS services.
   d. If the member chooses to continue enrollment with the CRS Contractor upon reaching age 21, the CRS Contractor will continue to be responsible for payment of CRS conditions and other covered services as specified by the member's CRS coverage type.

2. AHCCCS non-CRS Contractor Responsibilities when the Member Opts out of CRS (Under 21)

   Members who opt out of/or refuse enrollment with the CRS Program will be enrolled with another AHCCCS Contractor.

   For members who opt out/refuse enrollment with the CRS Contractor, the AHCCCS Contractor with whom the member is enrolled for acute care services is not responsible for coverage of the CRS condition except when a member uses private insurance or Medicare for a CRS covered condition as discussed below.

   a. Member has Third Party Coverage Benefits Available:
      i. If a member opts out/refuses enrollment with the CRS Contractor and uses private insurance or Medicare for treatment of the CRS condition, the AHCCCS Contractor with whom the member is enrolled for acute care services is responsible for all applicable deductibles and copayments remaining after payment by private insurance or Medicare.

b. Member has Exhausted Third Party Coverage Benefits:
   i. When the member's private insurance or Medicare does not make payment for treatment of the CRS condition, terminates, is exhausted for the CRS-covered condition, or when annual or lifetime limits are reached for the CRS covered condition, the AHCCCS Contractor with whom the member is enrolled for acute care services has no responsibility for coverage of the CRS condition.
   ii. Upon receipt of information that the member's private insurance or Medicare has terminated or has been exhausted with respect to the CRS covered condition, the AHCCCS Contractor with whom the member is enrolled for acute care services shall refer the member to DMS to evaluate the member for CRS eligibility.

In situations when the AHCCCS Contractor is not responsible for the CRS condition, the member may be billed by the provider as authorized by A.A.C. R9-22-702.

3. AHCCCS non-CRS Contractor Responsibilities (21 and Over)
   a. For members age 21 years or older, the AHCCCS Contractor with whom the member is enrolled for acute care services **IS** responsible for payment of services related to a CRS condition regardless of whether the member has private insurance or Medicare. The AHCCCS Contractor is the payor of last resort.

D. TERMINATION OF ENROLLMENT

DMS may terminate a member's enrollment with the CRS Contractor for the following reasons:

1. Member Loses Title XIX/XXI Eligibility
   a. If a member regains Title XIX/XXI eligibility within 12 months, the member will be re-enrolled with the CRS Contractor without a new referral/application being required.
   c. If AHCCCS eligibility is regained after 12 months, a new referral/application will be required for the CRS program.
   d. PPC with the CRS Contractor will only occur when a Title XIX CRS enrolled member loses eligibility and then regains eligibility within 12 months, resulting in re-enrollment with the CRS Contractor.

2. DMS Medical Eligibility Determination
   a. Member no longer meets the medical eligibility requirements for CRS.
   b. Member has completed treatment for the CRS condition(s).

3. Member/Authorized Representative Requests for Opt Out/Termination
   a. Members will be notified by DMS that any services related to the CRS condition will not be covered by another AHCCCS Contractor except when the member has private insurance or Medicare for the CRS condition in which case the non-CRS AHCCCS Contractor is responsible for payment of copayments and deductibles as outlined in Section IV (C) (2).
   b. The member (or the member's parent, legal guardian, or representative when applicable), will be required to sign an acknowledgement of understanding that CRS-related services will not be provided by the non-CRS Contractor and that the member agrees to accept payment responsibility for CRS services except when the member's private insurance or Medicare makes payment for CRS services. In these circumstances, the non-CRS AHCCCS Contractor shall pay the member's copayments and deductibles as outlined in Section IV(C)(2). Otherwise, the member shall be responsible for payment of services related to the CRS condition.

4. Member Transitions to ALTCS/EPD

5. Option to Disenroll After No Receipt of CRS Services for Three Years
   a. Starting in CYE15, during one designated time of the year determined by AHCCCS, AHCCCS will provide CRS Fully Integrated members who have been continuously enrolled in CRS and who have not received services for their CRS condition for three years, an option to disenroll from CRS.
   b. During this designated timeframe these Members will be allowed to choose an available Acute Care Contractor in their area.
   c. If it is later determined that the member needs care for a CRS condition, a CRS referral/application shall be submitted to DMS and evaluated for medical eligibility as described in this Policy.

E. NOTIFICATION OF CRS DISENROLLMENT

DMS will send written notice of CRS disenrollment to the member/authorized representative including a description of the member's hearing rights and information about the hearing process.

F. APPEAL OF CRS ELIGIBILITY DETERMINATIONS

A decision made by DMS to approve or deny a request for CRS enrollment, or to disenroll a CRS member, is subject to appeal under 9 A.A.C. 34.

G. REDETERMINATION

Continued eligibility for the CRS program shall be redetermined by verifying active treatment status of CRS qualifying medical conditions as described in A.A.C. R9-22-1305 and as follows:

1. CRS Notification
   a. The CRS Contractor is responsible for notifying AHCCCS of CRS members no longer requiring active treatment for the CRS qualifying condition(s).
   b. The CRS Contractor shall transmit to AHCCCS, the Members with Completed Treatment Report, on at least a monthly basis, for any CRS member who has completed treatment.
   c. The report must be sent no later than 15 days after the start of the month (reporting for the prior month) as specified in Attachment F, Contractor Chart of Deliverables.

2. AHCCCS Notification
   a. If AHCCCS determines that a CRS member is no longer medically eligible for CRS, AHCCCS shall provide the CRS member or authorized representative a written notice that informs the CRS member that AHCCCS is transitioning the CRS member's enrollment to another AHCCCS Contractor according to A.A.C. R9-22-1306.
   b. The member may appeal this determination under 9 A.A.C. 34.

III. REFERENCES

- ACOM Policy 434
- AMPM Chapter 300
- 9 A.A.C 34
- A.A.C. R9-22-702
- A.A.C. R9-22-1301 et seq.
- A.A.C. R9-22-1302
- A.A.C. R9-22-1303
- A.A.C. R9-22-1305
- A.A.C. R9-22-1306
- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D
- DES/CMDP Contract, Section D
- Attachment F, Contractors Chart of Deliverables